2017 Medical Benefits Highlights – Most/Local 77 Plans

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet at http://www.seattle.gov/personnel/resources/benefits_documents.asp.

Group Health Cooperative (GHC)	City of Seattle Traditional Plan		City of Seattle Preventive Plan	
	Preferred Provider	Non-Preferred Provider	Aetna In-Network	Out-of-Network
Deductible (per calendar year)				
No deductible	$400 per person $1,200 per family Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies	$1,000 per person $3,000 per family	$100 per person $300 per person Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the inpatient copay or emergency room copay applies	$450 per person $1,350 per family
Annual Out of Pocket Maximum (OOP Max) includes copays and coinsurance after any applicable deductible. Excludes prescription drug copays				
$2,000 per person $4,000 per family	$1,000 per person $3,000 per family	$2,000 per person $6,000 per family	$2,000 per person $4,000 per family	$3,000 per person $6,000 per family
Total Annual Out of Pocket Maximum: includes medical copays, coinsurance, and the deductible. Excludes prescription drug copays				
$2,000 per person $4,000 per family	$1,400 per person $4,200 per family	$3,000 per person $9,000 per family	$2,100 per person $4,300 per family	$3,450 per person $7,350 per family
Hospital Copay				
$200 per admission	$200 copay per admission	$200 copay per admission	$200 copay per admission	$200 copay per admission
Hospital Pre-admission Authorization				
Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission. Member responsible for obtaining precertification of out-of-network care.		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	Member responsible for obtaining precertification of out-of-network care
Choice of Providers				
All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to most GHC specialists.	Any Aetna contracted provider member. No primary care physician selection required. Aexcel specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.	Any Aetna contracted providers. No primary care physician selection or referrals required. Aexcel specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized* charges. You pay the difference between recognized and billed charges.

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COVERED EXPENSES				
Acupuncture				
$15 copay for up to 8 visits per condition per year self-referred. Additional visits when approved by plan.	Paid at 80% Paid at 60% Maximum of 12 visits per calendar year in-and out-of-network combined.		Paid at 100 after $15 copay Paid at 60% All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity.	
Alcohol/Drug Abuse Treatment				
Inpatient: Paid at 100% after $200 copay per admission Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 60% Outpatient: Paid at 60%
Contraceptives				
For contraceptive drugs and devices, see Prescription Drug benefit	Contraceptive devices and other products covered as medical benefits. (See Prescription Drugs.)		Contraceptive devices and other products covered as medical benefit. (See Prescription Drugs.)	Contraceptive devices and other products covered as medical benefit. (See Prescription Drugs.)
Durable Medical Equipment				
Paid at 80%	Paid at 80% Paid at 60% Breast pump covered at 100% through DME provider		Paid at 90% Paid at 60% Breast pump covered at 100% through DME provider	
Emergency Medical Care				
➢ **Urgent Care Clinic**				
Paid at 100% after $15 copay	Paid at 80% Paid at 60%		Paid at 100% after $15 copay (no fee for preventive care)	Paid at 60%
➢ **Emergency Room (copays waived if admitted)**				
GHC facility: Paid at 100% after $100 copay Non-GHC facility: Paid at 100% after $100 copay	Paid at 80% after $150 copay.	Paid at 80% after $150 copay. If not emergency, paid at 60%.	Paid at 90% after $150 copay	Paid at 90% after $150 copay. If non-emergency, paid at 60% after copay
➢ **Ambulance**				
Paid at 80% GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary. Non-emergency transport must be approved in advance.		Paid at 90% when medically necessary. Non-emergency transport must be approved in advance.	

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	Preferred Provider	Non-Preferred Provider	Aetna In-Network	Out-of-Network
Hospital Inpatient				
Paid at 100% after $200 copay	Paid at 80% after $200 copay. Physician services paid at 70% if Aexcel specialist not used in specialty areas.	Paid at 60% after $200 copay	Paid at 90% after $200 copay. Physician services paid at 80% if Aexcel specialist not used in specialty areas.	Paid at 60% after $200 copay
Hospital Outpatient				
Paid at 100% after $15 copay	Paid at 80% after deductible. Physician services paid at 70%if Aexcel specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible	Paid at 90% after deductible. Physician services paid at 80% if Aexcel specialist is not used in specialty areas.	Paid at 60% after deductible
Hospice				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 90%	Not covered
Maternity Care (delivery & related hospital)				
Paid at 100% after $200 copay per admission	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
Maternity Care (prenatal and postpartum)				
Paid at 100% after $15 copay. Routine care not subject to outpatient services copay	Paid at 80%	Paid at 60%	Paid at 90% after $15 copay	Paid at 60%
Mental Health Care (inpatient)				
Paid at 100% after $200 copay	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
Mental Health Care (outpatient)				
Paid at 100% after $15 copay	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay	Paid at 60% after deductible
Physician Office Visit				
Paid at 100% after $15 copay	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay	Paid at 60%

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Prescription Drugs (retail)				
For a 30-day supply: **Generic**: $15 copay **Brand**: $30 copay Contraceptive drugs and devices are covered in full. Selected preventive over-the-counter drugs covered at 100% in certain situations. Your pharmacy copays will apply to the annual out of pocket maximums.	For a 31-day supply: **Generic:** 30% coinsurance **Brand**: 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug is less. Maximum coinsurance is $100 per drug.	Not covered	For a 31-day supply: **Generic**: 30% coinsurance **Brand**: 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug is less. Maximum coinsurance is $100 per drug.	Not covered
	Coinsurance applies to the annual $1,200 out-of-pocket prescription maximum per person, $3,600 per family. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment): City pays $20 per month, participant pays remainder; some over the counter medications are also included. $5 copay for generic diabetic drugs and supplies, $15 copay for brand. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand. Selected preventive over-the-counter drugs covered at 100% in certain situations. Generic oral contraceptives are covered at 100%. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefits.		Coinsurance applies to the annual $1,200 out-of-pocket prescription maximum per person, $3,600 per family. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment): City pays $20 per month, participant pays remainder; some over the counter medications are also included. $5 copay for generic diabetic drugs and supplies, $15 copay for brand. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand. Selected preventive over-the-counter drugs covered at 100% in certain situations. Generic oral contraceptives are covered at 100%. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefits.	

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	Preferred Provider	**Non-Preferred Provider**	**Aetna In-Network**	**Out-of-Network**
Prescription Drugs (mail order)				
For a 90-day supply: **Generic**: $45 copay **Brand**: $90 copay Contraceptive drugs and devices are covered in full. No copay on all smoking cessation drugs through mail order. Your pharmacy copays will apply to the annual out of pocket maximums.	For a 90-day supply: **Generic**: 30% coinsurance **Brand**: 40% coinsurance Minimum is $20 or double the cost of the drug if less. Maximum is $200 per drug. Generic oral contraceptives covered at 100%.	Not covered	For a 90-day supply: **Generic**: 30% coinsurance **Brand**: 40% coinsurance Minimum is $20 or double the cost of the drug if less. Maximum is $200 per drug. Generic oral contraceptives covered at 100%.	Not covered
Prescription Drugs Annual Out of Pocket Maximum				
Included in annual out-of-pocket maximum	$1,200 per person $3,600 per family	Not covered	$1,200 per person $3,600 per family	Not Covered
Preventive Care				
Paid at 100% for adult physical and well child exams and most immunizations and preventive services	Paid at 100% Covers adult physical and well child exams, immunizations, digital rectal exams/PSA, colorectal cancer screening	Paid at 60% for mammograms, deductible waived. No other preventive services covered.	Paid at 100% Covers adult physical and well child exams, immunizations, digital rectal exams/PSA, colorectal cancer screening	Paid at 60% for well woman care and mammograms. No other preventive services covered.
Rehabilitation Services (inpatient)				
Paid at 100% after $200 copay per admission. Maximum of 60-days per calendar year for occupational, speech, and physical therapy.	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 100% after $15 copay 120 days per calendar year for skilled nursing and rehab services in-network and out-of-network combined.	Paid at 60%

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Rehabilitation Services (outpatient)				
Paid at 100% after $15 copay Maximum of 60 visits per calendar year for occupational, speech, and physical therapy.	Paid at 80%	Paid at 60%	Paid at 100% after $200 copay	Paid at 60%
	Includes medically necessary physical/massage, speech, occupational and cardiac/pulmonary therapy for non-chronic conditions. Coinsurance does not apply to OOP Max. Coverage of services subject to Aetna's review for medical necessity at any time.		Includes medically necessary physical/massage, speech, occupational and cardiac/pulmonary therapy for non-chronic conditions. Coinsurance does not apply to OOP Max. Coverage of services subject to Aetna's review for medical necessity at any time.	
Skilled Nursing Facility				
Paid at 100%; 60 day maximum per calendar year	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
	Maximum of 90 days per calendar year		Maximum of 120 days per calendar year for in-network and out-of-network combined	
Smoking Cessation				
Paid at 100% for individual/group sessions through Quit For Life. Nicotine replacement therapy included in Prescription Drugs benefit. No copay on all smoking cessation prescription drugs through mail-order.	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail.	Not covered	Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance	Not covered
Spinal Manipulations				
Paid at 100% after $15 copay. Self-referral to GHC-designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay	Paid at 60%
	Maximum of 10 visits per year for in-network and out-of-network combined		Maximum of 20 visits per calendar year for in-network and out-of-network combined	
Sterilization Procedures				
Inpatient: Paid at 100% after $200 copay Outpatient: Paid at 100% after $15 copay Women's sterilization procedures covered in full	Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 90%.	Paid at 60% after $200 copay Outpatient: Paid at 60%
Tooth Injury (due to accident)				

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Not covered	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100% after $15 copay	Paid at 60% after $200 copay Outpatient: Paid at 60%
Vision Exam/Hardware				
Exam: Paid at 100% after $15 copay. One exam every 12 months. Hardware: Not included	Covered under VSP		Covered under VSP	
X-ray and Lab Tests (Outpatient)				
Paid at 100%	Paid at 80% Provider responsible for precertification of high tech radiology	Paid at 60%	Paid at 90% Provider responsible for precertification of high tech radiololgy	Paid at 60%

* Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

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